The James L. Dennis Developmental Center
1301 Wolfe Street
Little Rock, Arkansas 72202

Clinic Telephone Number: (501) 364-1830
Fax: (501) 364-4967

INTAKE REQUEST (Part 1: Physician)

Date of Request _____

PATIENT NAME _____
Last First Middle

Patient Date of Birth:	**Age:**	**Sex:**	**Race:**
Patient Street Address:			
Patient Town/City:	**Zip Code:**	**County:**	
Home Telephone: (Include Area Code)			
Parents or Legal Guardian of Patient:			
Work Telephone:	**Message Telephone:**		
Primary Care Physician:			
PCP Telephone:	**PCP Fax:**		

Is this appointment a first time visit or a follow up visit to the DDC?

_____ First Time Visit
_____ Follow-up Visit (___For Medical ___For Testing)

PLEASE NOTE: The ***Dennis Developmental Center specializes*** in the assessment of developmental conditions that result in delayed milestones, inability to communicate effectively, inattention, hyperactivity, impulsivity, learning problems, and poor or atypical social interactions. Evaluation and therapy are also provided for families coping with the stress of chronic developmental disorders or chronic medical illnesses, and with grief and loss concerns. ***Please refer your patient to the Child and Adolescent Psychiatric Division (Child Study Center at 501-364-5150) at Arkansas Children's Hospital or your local mental health agency*** *for diagnosis or treatment of disorders that are primarily psychiatric (i.e., bipolar disorders, anxiety disorders, oppositional defiant disorder, conduct disorder, personality disorders, etc.) or issues related to child abuse or custody.*

What is the PRIMARY concern for this referral? PLEASE CHECK	
o **Developmental Delay**	o **Medication Consultation**
o **Autism Spectrum (Autism, Pervasive Developmental Disorder (PPD), Asperger's)**	o **Problems coping with developmental disorders and/or chronic medical conditions (i.e., evaluation and therapy)**
o **ADD/ADHD**	o **Medical crisis or loss concerns**
o **Learning Impairment**	o **Speech or Language Impairment**
o **Neuropsychological Evaluation**	o **Other:**
What is your goal of this evaluation?	

Serious illnesses or major medical problems? ____No ____Yes **If YES, please list problems:**	
Vision Problems? ____No ____Yes	**Hearing Problems?** ____No ____Yes
Has the child previously received mental health diagnosis or treatment? ____No ____Yes **If YES, please list:**	
Does this child take any medications on a regular basis? ____No ____Yes **If YES, please list:**	
Comments: Is there anything else you would like us to know about the child?	

PRIMARY INSURANCE:	***SECONDARY INSURANCE:***
Policy Holder and Date of Birth:	Policy Holder and Date of Birth:
Policy/Group #:	Policy/Group #:
ID #:	ID #:
Insurance Co. Phone #:	**Insurance Co. Phone #:**
Employer:	Employer:
Federal ___No ___Yes State ___No ___Yes	Federal ___No ___Yes State ___No ___Yes

Form completed by: _____